(2) The mean times are used to assist in the determination of whether a facility has the capacity to render services to its existing population based upon its current staffing pattern. For example, a facility having "X" number of registered nurses can handle only so many residents requiring the services of a registered nurse; a facility without specialized programs for the mentally retarded cannot handle residents with the primary diagnosis of mental retardation.

~~(F) Each unit or category within a standard has a predetermined number of points to determine whether the resident is residing in a facility which is equipped and capable of rendering the type of services needed by the resident from a level of care perspective. The point value scale does not directly affect payments. Its purpose is an internal management tool designed to monitor that the decisions of the resident review process are internally consistent, and to provide an indication regarding the resident's level of care needs. The points are defined as follows:~~

~~(1) "0" - No nursing or medical habilitation service is needed or being provided.~~

~~(2) "1" - The service being provided contains elements of medical, personal and/or social care, with intermittent provisions of nursing care, but emphasizes primarily the personal supervision, protection, and assistance of the resident.~~

~~(3) "2" - The service being provided is primarily nursing in nature, and is one aspect of a medically oriented program of static, uncomplicated treatment plans in which the resident's condition has stabilized.~~

~~(4) "4" - The service being provided requires the direct application of the skills of a registered nurse, licensed practical nurse with specialized training, or other licensed specialist (e.g., physical therapist).~~

~~(5) "8" - The service being provided requires the direct application of the skills of a registered nurse or other licensed specialists as part of the habilitation program.~~

~~(G)~~ (F) Federal regulations governing medicaid identify three classifications of facility certifications. The criteria for corresponding levels of care are defined in rules 5101:3-3-05 ("SKILLED NURSING CARE OR SKILLED REHABILITATION SERVICES") to 5101:3-3-07 ("MR/DD LEVEL

Proposed Effective Date August 1, 1989

OF CARE") of the Administrative Code. These levels of care are used to ensure proper placement of residents. Under the resident review process the ~~department's nurse specialists~~ REVIEW TEAM and professional review consultants will reference supplemental levels of care to reflect ranges of service and to identify characteristics of residents not needing the kind of care provided in LTCFs. These additional levels of care are referenced only for data assimilation and planning purposes and do not affect either payment to the LTCF or placement UNTIL THE FINAL LEVEL OF CARE DECISION HAS BEEN MADE. REFERENCE RULE 5101:3-3-15 ("UTILIZATION CONTROL") OF THE ADMINISTRATIVE CODE FOR SPECIFIC INFORMATION REGARDING UTILIZATION REVIEW PROCESS.

~~(1) "Maximum intermediate care level" means that a resident's medical condition has stabilized and requires ongoing institutional medical and nursing services of an uncomplicated or static nature.~~

~~(2) "Restorative intermediate care level" means that a resident's medical and health condition requires, in addition to ongoing medical and nursing services of an uncomplicated or static nature, an active treatment program designed to achieve measurable behavioral objectives, including maximum functional capacity. This category includes residents with chronic conditions who can benefit from restorative and rehabilitative services. This category does not include residents with an ICF-MR level of care.~~

~~(3) "General intermediate care level" means that a resident's health related condition requires ongoing institutional health care services, but not necessarily ongoing provision of routine nursing care. Periodic, episodic, or intermittent need for nursing care is included in this category, in addition to the regular provision of health related care of supervision of medication, personal hygiene, and behavior activities; regular diets; and diversional and motivational activities.~~

~~(4)~~ (1) "Protective level of care" means that a resident's medical and health-related condition does not warrant institutional or health-related services, but does require a protective living environment in which personal care and supplemental services are provided in addition to room and board. This category includes individuals who are able to reside in supervised living arrangements such as a rest home, group home, or adult foster care home.

Proposed Effective Date August 1, 1989

TNS # 89-26 APPROVAL DATE 1/13/89
SUPERSEDES TNS # 87-9 EFFECTIVE DATE 8/1/89

~~(5)~~ (2) "Noninstitutional level of care" means that a resident's medical and health-related condition does not warrant institutional medical or health-related services. This category includes individuals who are able to reside in independent living arrangements.

Effective Date: _____

Certification: _____

_____
Date

Promulgated Under RC Chapter 119.
Rule amplifies RC§ 5111.02, 5111.23(D) and 5111.29
Prior Effective Date: 7/1/80, 1/30/87 (Emer.), 5/1/87, 8/1/89 (Emer.)

Proposed Effective Date August 1, 1989

TNS # 89-26
SUPERSEDES TNS # 87-9

APPROVAL DATE 11/13/89
EFFECTIVE DATE 8/1/89

4/19-D

5101:3-3-13 Computation of additional allowance for nonmeasured nursing and habilitation services, therapeutic value of nursing presence, nonproductive time, and administrative/supervisory time.

The mean time for rendering a particular service contained in rules 5101:3-3-30 to 5101:3-3-33, 5101:3-3-35, 5101:3-3-40, and 5101:3-3-44 of the Administrative Code was multiplied by a composite percentage of paragraphs (A) to (D) of this rule to determine the additional time allocated in paragraph (D) of rules 5101:3-3-30 to 5101:3-3-33, 5101:3-3-35, and 5101:3-3-40 of the Administrative Code and paragraph (F) of rule 5101:3-3-44 of the Administrative Code for the purpose of implementing paragraph (D)(2) of rule 5101:3-3-12 of the Administrative Code.

(A) The additional allowance for nonmeasured nursing and habilitation services is twenty-one per cent for services rendered by a registered nurse, forty-one per cent for services rendered by a licensed practical nurse, and eleven per cent for services rendered by a nurse's aide. This was added for the services rendered in rules 5101:3-3-30 to 5101:3-3-33, 5101:3-3-35, 5101:3-3-40, and 5101:3-3-44 of the Administrative Code.

(B) The additional allowance for nonproductive time is seven per cent for a registered nurse, fourteen per cent for a licensed practical nurse, and seventeen per cent for a nurse's aide. This was added for services rendered in rules 5101:3-3-30 to 5101:3-3-33, 5101:3-3-35, 5101:3-3-40, and 5101:3-3-44 of the Administrative Code.

(C) The additional allowance for administrative/supervisory time is thirty per cent.

(1) This was added for services rendered in rules 5101:3-3-30 to 5101:3-3-32, 5101:3-3-35, 5101:3-3-40, and 5101:3-3-44 of the Administrative Code and paragraphs (C)(2) and (C)(3) of rule 5101:3-3-33 of the Administrative Code.

(2) This is the allowance to cover the reasonable costs for medical director, director of nursing, supervising nurses, medical records personnel, pharmaceutical consultants, other medical consultants, social service and recreational therapists performing general functions such as admission, discharge planning and program planning, the purchase of nursing service from pools, fringe benefits excluding payroll taxes, and training activities.

(D) The additional allowance for the restorative service known as "nursing presence" is added to services which would not increase a patient's dependence upon institutional services.

(1) This is in addition to the allowance for general restorative nursing contained in all the time values created as a result of the allowance for direct care services (reference: paragraph (D)(1) of rule 5101:3-3-12 of the Administrative Code) being at the eighty-fifth percentile of time necessary to render the service.

(2) The additional allowance is ten per cent for services rendered under paragraph (C)(2) of rules 5101:3-3-30, 5101:3-3-32, and 5101:3-3-33 of the Administrative Code, twenty per cent for services rendered under paragraph (C)(2) of rules 5101:3-3-31, 5101:3-3-35, and 5101:3-3-40 of the Administrative Code, ten per cent for services rendered under paragraph (C)(3) of rule 5101:3-3-31 of the Administrative Code, and twenty per cent for services rendered under paragraph (C)(3) of rule 5101:3-3-33 of the Administrative Code.

PO 82-16 Rec'd 9/29/82
ORIGINALLY
☒ Approved 9/02/82
☐ Send ☐
Init. J.Z. Date

5101:3-3-14 Resident review process.

This rule describes the resident review process itself and identifies how, when appropriate, the resident review process incorporates utilization control activities.

(A) Resident review team

The resident review team consists of physicians or registered nurses who are knowledgeable of the problems of the aged, individuals knowledgeable of the treatment of mental retardation, and other appropriate health and social service personnel as determined by the department. Onsite reviews will routinely be conducted by the registered nurse members of the team. As described elsewhere in this rule, other team members will at certain times be involved in onsite reviews and will be otherwise available for consultations. The following provisions are applicable to all team members:

(1) No member of the team that reviews care in an SNF may have a financial interest in or be employed by that SNF AT THE TIME OF THE REVIEW OR ANY TIME DURING THE SIX MONTHS PRECEDING THE REVIEW.

(2) No member of the team that reviews care in an ICF may have a financial interest in or be employed by that ICF AT THE TIME OF THE REVIEW OR ANY TIME DURING THE SIX MONTHS PRECEDING THE REVIEW.

(3) No member of the team that reviews care in an ICF-MR may have a financial interest in or be employed by that ICF-MR AT THE TIME OF THE REVIEW OR ANY TIME DURING THE SIX MONTHS PRECEDING THE REVIEW.

(4) No physician member of the team may inspect the care of a resident for whom he is the attending physician.

(B) Process followed by the department in conducting the resident review process

A team of two registered nurses, or a registered nurse and/or one other allied health or social services professional, or AT LEAST one registered nurse will review residents' plans of care to determine the needs of residents and will review the medical/PROGRAM records, nurses' notes, etc., to determine the actual services delivered. One member of the review team for an ICF-MR will be a qualified mental retardation professional (QMRP).

(1) The review will be conducted at the facility.

Proposed effective date August 1, 1989

TNS # 89-26
SUPERSEDES
TNS # 87-9

APPROVAL DATE 11/3/89
EFFECTIVE DATE 8/1/89

(2) The review will cover the resident's need and facility's delivery of services during a specific period.

(3) In order to provide adequate time for all LTCF providers and departmental staff to implement the revised resident review process, the following review schedule will be implemented:

(a) LTCFs reviewed in ~~January, 1987~~ AUGUST, 1989: The months of ~~October, November~~ MAY, JUNE and ~~December, 1986~~ JULY, 1989 will be reviewed ~~on~~ ACCORDING TO the ~~patient assessment system utilized prior to January 30, 1987~~ RESIDENT REVIEW PROCESS UTILIZED PRIOR TO AUGUST 1, 1989.

(b) LTCFs reviewed in ~~the months of February, March, and April, 1987~~ SEPTEMBER, 1989: ~~Only an inspection of care review will be performed; rate setting reviews will not be conducted in these three months~~ THE MONTHS OF JUNE AND JULY, 1989 WILL BE REVIEWED ACCORDING TO THE RESIDENT REVIEW PROCESS UTILIZED PRIOR TO AUGUST 1, 1989.

(c) LTCFs reviewed in ~~the month of May, 1987~~ OCTOBER, 1989: The ~~month of April, 1987,~~ MONTHS OF AUGUST AND SEPTEMBER, 1989 will be reviewed ~~utilizing~~ ACCORDING TO the ~~revised~~ resident review ~~system~~ PROCESS WHICH IS EFFECTIVE AUGUST 1, 1989.

(d) LTCFs reviewed in ~~the month of June, 1987~~ NOVEMBER, 1989: The ~~month of April and May, 1987,~~ MONTHS OF AUGUST, SEPTEMBER, AND OCTOBER, 1989 will be reviewed ~~utilizing~~ ACCORDING TO the ~~revised~~ resident review process WHICH IS EFFECTIVE AUGUST 1, 1989.

~~(e) LTCFs reviewed in the month of July, 1987: The months of April, May and June, 1987, will be reviewed utilizing the revised resident review process.~~

(4) The findings of the review team relative to the needs of the resident and the service delivery of the facility will be shared with the director of nurses (or other designated facility representative) at the time of the review in order to provide an opportunity for the facility to bring to the attention of the review team any factor that might have been overlooked.

Proposed Effective Date August 1, 1989

TNS # 89-26
SUPERSEDES
TNS # 87-9

APPROVAL DATE 11/13/89
EFFECTIVE DATE 8/1/89

(a) The recording of services needed and/or delivered (which determines a facility's ceiling and possible disallowance of costs) simply reflects the service ordered by a physician or QMRP where applicable as documented in a plan of care, or individual habilitation plan, and the services delivered by the facility as documented in nurses' notes and medical/PROGRAM records.

(b) LTCFs shall submit ~~any~~ TO THE BUREAU OF RESIDENT SERVICES, ODHS, AN appeal on any dispute regarding ~~the~~ CREDIT GIVEN FOR services needed AND/or ~~rendered to any particular resident to the bureau of resident services, ODHS, within seventy-two hours~~ DELIVERED. MATERIAL SUBMITTED MUST BE POSTMARKED WITHIN FOURTEEN CALENDAR DAYS OF THE EXIT CONFERENCE. An appeal must include THE FOLLOWING: ~~a detailed~~ AN explanation of the ~~problem~~ REASON FOR FILING THE APPEAL; A STATEMENT OF THE NEEDED AND DELIVERED SERVICE UNIT LEVELS THE FACILITY RECEIVED AND THE SERVICE UNIT LEVELS THE FACILITY BELIEVES SHOULD HAVE BEEN GRANTED; COPIES OF ALL DOCUMENTS REVIEWED DURING THE RESIDENT REVIEW PROCESS BY THE REVIEW TEAM THAT ESTABLISHED NEED AND VERIFIED DELIVERY (INCLUDING CERTIFICATION/RECERTIFICATION STATEMENTS); and A notarized ~~copies of documentation as described in paragraph (B)(4) of this rule~~ STATEMENT THAT STATES THE SUBMITTED MATERIAL HAS NOT BEEN ALTERED SINCE THE TIME OF THE REVIEW AND THAT THE DOCUMENTS WERE THOSE REVIEWED BY THE REVIEW TEAM DURING THE RESIDENT REVIEW PROCESS. RECORDS FOR NO MORE THAN FOUR INDIVIDUALS PER STANDARD MAY BE SUBMITTED. DOCUMENTATION MEETING THE ABOVE CRITERIA FOR EACH STANDARD WILL BE REVIEWED. IF THE RECORDS FOR MORE THAN FOUR INDIVIDUALS ARE SUBMITTED FOR ONE STANDARD, THAT STANDARD WILL NOT BE CONSIDERED AS PART OF THE APPEAL.

(c) IF ALL ABOVE REQUIREMENTS ARE MET, ~~The~~ THE documentation shall be reviewed and the facility notified of the result ~~prior to final settlement for the months under review~~ WITHIN A PERIOD OF TIME NOT TO EXCEED NINETY DAYS.

(d) Unresolved disputes between the department and the LTCF on findings submitted in accordance with paragraph (B)(4) of this rule are appealable at the time of final settlement in accordance with paragraph (A) of rule 5101:3-1-57 ("PROCESS FOR PROVIDER APPEALS FROM PROPOSED DEPARTMENTAL ACTIONS") of the Administrative Code.

Proposed Effective Date August 1, 1989

TNS # 89-26
SUPERSEDES
TNS # 87-9

APPROVAL DATE 11/13/89
EFFECTIVE DATE 8/1/89

(5) The review will also include resident observations to identify discrepancies between the observed resident's condition and the resident's condition as reflected in the plan of care, and the services delivered by the facility as reflected in medical/PROGRAM records.

(a) A referral will be made to the licensing agency or other responsible agency or a follow-up visit may be made by a physician, peer review consultant, and/or a ~~resident~~ review TEAM ~~nurse specialist~~ supervisor for any resident whose medical and health-related needs (as reflected in the plan of care, medical/PROGRAM records, nurses' notes) do not correspond to the observation of the resident's needs or, when despite entries in the records, it appears that a service recorded as delivered has not been delivered. In these instances there may be a consultation with the resident's physician and medical/nursing staff of the facility and the assessment of the individual will be revised according to the findings of the follow-up visit.

(b) The results of a follow-up visit to investigate the apparent discrepancies between the resident review staffs' observations of resident's need and facility's service delivery, and the resident's written plan of care, medical/PROGRAM records, and nurses' notes (as described in paragraph (B)(5) of this rule) are appealable under provisions set forth in paragraph (B) of rule 5101:3-1-57 ("PROCESS FOR PROVIDER APPEALS FROM PROPOSED DEPARTMENTAL ACTIONS") of the Administrative Code.

(6) The reviewers will also determine the resident's level of care at the time the review is conducted, based on the level of care definitions contained in paragraph (G) of rule 5101:3-3-12 ("RESIDENT REVIEW PROCESS: GENERAL PROVISIONS") of the Administrative Code. In LTCFs which provide SERVICES TO RESIDENTS WITH skilled LEVELS OF care, the levels of care entered on the resident review form by department resident review staff will, in such instances, be used only for internal management reasons.

(C) Utilization review activities of resident review

The resident review process described in paragraph (B) of this rule includes certain utilization control activities.

(1) Utilization review for ICF and ICF-MR ~~patients~~ RESIDENTS.

Proposed Effective Date August 1, 1989

The department performs utilization review for ICF and ICF-MR residents concurrently with the performance of the resident review process as identified in paragraph (B) of this rule. The ~~department's nurse specialists and/or peer review consultants~~ ODHS REPRESENTATIVE(S) utilize the level of care criteria identified in rules 5101:3-3-05 ("SKILLED NURSING CARE OR SKILLED REHABILITATIVE SERVICES") to 5101:3-3-07 ("ICF/DD LEVEL OF CARE") of the Administrative Code. For purposes of utilization review, the levels of care identified in rule 5101:3-3-12 ("RESIDENT REVIEW PROCESS: GENERAL PROVISIONS") of the Administrative Code as ~~maximum intermediate care, restorative intermediate care and general intermediate care are all considered as ICF care. Those levels of care identified as~~ protective and noninstitutional care are considered ~~as~~ levels not requiring continued stay in an LTCF. EACH SKILLED NURSING FACILITY IS REQUIRED PER 42 CFR 456.300 ET SEQ. TO PERFORM UTILIZATION REVIEW FOR SKILLED NURSING FACILITY SERVICES. THE SKILLED LEVEL OF CARE AS DETERMINED BY THE FACILITY UTILIZATION REVIEW COMMITTEE WILL BE RECORDED BY THE ODHS REPRESENTATIVE(S) ON DEPARTMENTAL FORMS.

(a) If the ~~nurse specialist or peer review consultant~~ ODHS REPRESENTATIVE(S) determines that a resident's continued stay in the ICF or ICF-MR is needed, the new continued stay review date is assigned in accordance with the next scheduled resident review.

(b) If the ~~nurse specialist or peer review consultant~~ ODHS REPRESENTATIVE(S) identifies a resident with a potential adverse level of care, a referral will be sent to the utilization review coordinator at ODHS. The coordinator will send a copy of the referral to the LTCF and the ODHS to request additional information.

(c) If the ODHS utilization review committee determines that a continued stay in the LTCF is not warranted, the department notifies the resident's attending physician, LTCF, and ODHS; or in an ICF-MR, the QMRP responsible for the resident's plan of care, within one working day of the committee's decision. The resident's attending physician, or QMRP when appropriate, has two working days from the notification date to present views before a final decision is made by the committee.

(i) If the attending physician or QMRP does not present additional information or clarification of the need for the continued stay, the decision of the utilization committee is final.

Proposed Effective Date August 1, 1989

(ii) If the attending physician or QMRP presents additional information or clarification, the need for a continued stay is again reviewed by either the physician member(s) in cases involving a medical determination, or by other member(s) in cases not involving a medical determination. If the individuals of the committee performing the review determine that the resident no longer needs ICF or ICF-MR services, their determination is final.

(iii) Not later than two working days after the date of a final decision, a written notice of any adverse final decision will be sent to the ICF or ICF-MR administrator; the attending physician or QMRP if applicable; the resident and, if possible, the next of kin or sponsor; and the county department of human services.

(2) Inspection of care in SNFs, ICFs and ICFs-MR

The department is required to assure that designated teams periodically inspect the care and services provided to residents in each facility. This inspection will be conducted as follows:

(a) Frequency of inspections

The team and the department determine, based on the quality of care and services provided in the facility and the condition of residents in the facility, at what intervals inspections will be made. However, at least annually, one resident review process as defined in paragraph (B) of this rule will be supplemented by a team inspection of the care and services provided to each resident in the facility.

(b) Inspection team determinations

The team's inspection includes contact with and observation of each resident, review of each resident's medical/PROGRAM record, and a general review of the facility to determine whether:

(i) The services available in the facility are adequate to meet the health and safety needs, and the rehabilitation and social needs of each resident in an ICF, SNF, and ICF-MR; and promote each resident's maximum physical, mental, and psychosocial functioning.

Proposed Effective Date August 1, 1989

TNS # 89-26 APPROVAL DATE 11/13/89
SUPERSEDES TNS # 87-9 EFFECTIVE DATE 8/1/89